BQC - 92 – 014

Date: April 30, 1992

To: Facilities for the Developmentally Disabled FDD 6
Staff 14

From: Larry Tainter, Director
Bureau of Quality Assurance

Subject: Discharge plans for developmentally disabled clients in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

It has come to our attention that some ICFs/MR do not have discharge plans for one or more clients because they do not anticipate a need to discharge the client(s). The intent of active treatment is to assist the client to acquire the behaviors and skills necessary to function with as much self-determination and independence as possible. This intent implies that a client may eventually acquire sufficient skills so s/he is generally independent and not in need of active treatment and institutional placement. In addition, many other clients, who require continuing active treatment, would benefit from a community placement or other alternative placement. The intent of active treatment for these clients is to assist them in the acquisition of skills necessary for successful community placement. Therefore, each client must have a discharge plan which assesses their need for an alternative placement and describes the criteria for implementation of this plan.

The Medicaid regulations dealing with utilization control in intermediate care facilities at 42 CFR 456.380, state:

(a) Before admission to an ICF or before authorization for payment, a physician must establish a written plan of care for each applicant or recipient.
(b) The plan of care must include—
  (1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
  (2) A description of the functional level of the individual;
  (3) Objectives
  (4) Any orders for—
    (i) Medications;
    (ii) Treatments;
    (iii) Restorative and rehabilitative services;
    (iv) Activities;
    (v) Therapies;
    (vi) Social services;
    (vii) Diet; and
    (viii) Special procedures designed to meet the objectives of the plan of care;
  (5) Plans for continuing care, including review and modification of the plan of care; and
  (6) <u>Plans for discharge</u> (emphasis added)

The team must review each plan of care at least every 90 days.

Note: This is also the code requirement referenced in the HCFA Regional Program Letter #90-33 which was part of BQC memo #BQC-91-019 issued on April 29, 1991. In this memo is an interpretation of W260, that states “42 CFR 456.380(c) requires the team to review the IPP at least every 90 days. Since this regulation is more stringent, it must be the controlling regulation.”

Failure to meet the requirement of CFR 456.380 may in turn directly affect the facility’s compliance with the following code requirements:

HSS 134.60(1)(c)2. Interdisciplinary Review.

CFR 483.440(c) Individual Program Plan.

CFR 483.440(f) Program monitoring and change.

Both the state and federal code require the participation of the client, parent (if the client is a minor), or the client's guardian in interdisciplinary team meetings which design and review the client's individual program plan (IPP), unless the participation is unobtainable or inappropriate. If these requirements are met, there should not be any surprises to the client or the client's family regarding discharge plans, if a discharge is imminent.

The following information must be documented somewhere in the client's chart:

1. The reasons for admission,

2. The objectives for the client's care and treatment,

3. The expected duration of the client's stay in the facility, and

4. Recommendations for alternative programs and services in the community if the client is discharged. The recommendations for alternative programs and services may also include the need for transfer to another building in the facility, transfer to another ICF/MR, or the need for programs and services the client is not currently receiving.

The initial discharge plan and subsequent reviews of the discharge plan need to integrate information so it is clear why the interdisciplinary team is recommending that the client stay in the current placement, transfer to another room, building, or facility, or be discharged into the community. If the team foresees that discharge may be possible now or some time in the future, then the team must document specific recommendations for alternative programs and services. If the team believes that discharge is not anticipated at some time, the team must indicate the criteria that would cause a change in this determination.

Surveyors will be monitoring for compliance with this requirement routinely during standard surveys.

If you have questions regarding this memo, contact the Field Operations Manager assigned to your facility.

LT/DZ:jh disch3

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-Minnesota State Agency
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-Service Employees Intern. Union
-WI Counties Assn.
-WI Medical Records Assn. Cons. Comm.
-WI Assoc. of Homes and Services for Aging
-Comm. on Aging, Ext. Care Fac./HH (SMS)
-WI Assn. of Nursing Homes
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